HEALTH HISTORY

Welcome to our Practice. As a new patient, please fill out the information found below to the best of your ability.

Date: ______________________

Patient Name ________________________________ Birthdate ______________ Patient # ______________

SSN/SIN ______________ ☐ Male ☐ Female Primary Care Physician ______________________________

Address ____ Home Phone ______________________

E-Mail ____ Cell Phone ______________________

Employer __________________________ Occupation ______________________ Work Phone ______________________

Eye History

Have you ever had the following eye conditions? (Circle "no" or "yes", leave blank if uncertain) **Explanation**

Condition			Explanation
Glaucoma, Cataracts, Etc.	No	Yes	
Loss of Vision	No	Yes	
Blurred Vision	No	Yes	
Fluctuating Vision	No	Yes	
Distorted Vision	No	Yes	
Loss of Side Vision	No	Yes	
Double Vision	No	Yes	
Dryness	No	Yes	
Mucous Discharge	No	Yes	
Redness	No	Yes	
Lazy Eye/Crossed Eye	No	Yes	
Sandy or Gritty	No	Yes	
Itching	No	Yes	
Burning	No	Yes	
Foreign Body Sensation	No	Yes	
Excess Tearing	No	Yes	
Glare/Light Sensitivity	No	Yes	
Pain or Soreness	No	Yes	
Infection	No	Yes	
Tired Eyes	No	Yes	
Drooping Eyelid	No	Yes	
Other	No	Yes	

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

________________________________ ______________ ______________________

________________________________ ______________ ______________________

________________________________ ______________ ______________________

Medications: (Include Non-Prescription) ________________________________

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Have you ever taken Fen-Phen/Redux? Yes No

Patient Social History: (Circle Appropriate Answer)

Marital Status: Single Married Separated Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Previously, but not in the past ______ year(s) Current packs/day: __________

Do you have visual difficulty when driving? Yes No

Do you currently wear: Contact Lenses Glasses Neither

Family Medical History:

	Age	Medical/Eye Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

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Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
- Good general health lately ..... No Yes
- Recent weight change .... No Yes
- Fever .... No Yes
- Fatigue .... No Yes

☐ **Ears/Nose/Mouth/Throat**
- Earaches or drainage .... No Yes
- Chronic sinus problem or rhinitis No Yes
- Nose bleeds .... No Yes
- Mouth sores .... No Yes
- Bleeding gums .... No Yes
- Bad breath or bad taste .... No Yes
- Hearing loss or injury .... No Yes
- Sore throat or voice change .... No Yes

☐ **Neurological**
- Numbness or tingling sensation . No Yes
- Paralysis .... No Yes
- Headaches .... No Yes
- Light headed or dizzy .... No Yes
- Convulsions or seizures .... No Yes
- Tremors .... No Yes
- Head injury .... No Yes

☐ **Hematologic/Lymphatic**
- Anemia .... No Yes
- Bleeding or bruising tendency .. No Yes
- Slow to heal after cut .... No Yes
- Phlebitis .... No Yes
- Past transfusion .... No Yes
- Enlarged glands .... No Yes

☐ **Respiratory**
- Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? .... No Yes
- Shortness of breath .... No Yes
- Wheezing .... No Yes
- Spitting up blood .... No Yes
- Tuberculosis .... No Yes

☐ **Gastrointestinal**
- Loss of appetite .... No Yes
- Change in bowel movements ... No Yes
- Frequent diarrhea .... No Yes
- Nausea or vomiting .... No Yes
- Painful bowel movements or constipation .... No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain .... No Yes

☐ **Psychiatric**
- Memory loss or confusion ...... No Yes
- Depression .... No Yes
- Nervousness .... No Yes
- Insomnia .... No Yes

☐ **Cardiovascular**
- Heart trouble .... No Yes
- Chest pain or angina pectoris ... No Yes
- Palpitation .... No Yes
- Shortness of breath w/walking or lying down .... No Yes
- Swelling of feet, ankles or hands. No Yes

☐ **Musculoskeletal**
- Joint pain .... No Yes
- Joint stiffness or swelling .... No Yes
- Muscle pain or cramps .... No Yes
- Weakness pain or cramps ...... No Yes
- Back pain .... No Yes
- Cold extremities .... No Yes
- Difficulty in walking .... No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics ... No Yes
- Morphine, Demerol, or other narcotics .... No Yes
- Novocain or other anesthetics .. No Yes
- Aspirin or other pain remedies .. No Yes
- Tetanus antitoxin or other serums .... No Yes
- Iodine, Merthiolate or other antiseptics .... No Yes

Other drugs/medications: ____________

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Known food allergies: ____________

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____________ ____________

Signature of Patient or Guardian if Minor Date

Doctor's Review

____________ ____________

Signature of Doctor Date